DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES
POLICIES AND PROCEDURES

Compliance Verification Protocol

for Client Specific, Time Limited

Out-of-State Enrollment for Residential Services

APRIL 2002

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Mental Health, Developmental Disabilities and Substance Abuse Services
Child And Family Service Section and Program Accountability Section
and the
Division of Medical Assistance

Compliance Verification Protocol for Client Specific, Time Limited Out-of-State Enrollment for Residential Services

Table of Contents

Policy

Purpose 2

Scope 2

Policy Statement 3

Enforcement 4

Exceptions 4

Procedure 5

List of Attachments 7

Out-of-State (OOS) Placement Request Checklist 8

Placement Request Guideline Form 9

Out-of-State Placement Acknowledgement/Support Statement 12

PRTF Criteria, Medicaid Special Bulletin IV, December 2001 13

Child Level of Care Criteria for Mental Health and Substance Abuse Treatment Services Revised Edition, December 2001 16

Directory of Contacts 23

Web Sites 24

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES
POLICIES AND PROCEDURES

Section:	Child & Family Services	**Effective Date:**	Upon signature
Branch:	System of Care, Resource Development	**Policy No.**	CF- 101
Section:	Program Accountability		
Subject:	Out-of-state child residential placements	**Revision date :**	

Approved By: _____ **Approval Date:** 4-1-02
Section Chief

Approved By: _____ **Approval Date:** 4-1-02
Section Chief

Approved By: _____ **Approval Date:** 4-26-02
Division Director/Designee

Purpose:

This policy was developed in cooperation between the Child and Family Services Section (CFS) and the Program Accountability Section (PA) of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, along with the Division of Medical Assistance (DMA), in order to provide clear and consistent protocols for assessing out-of-state (OOS) placements for youth who are residents of North Carolina. Further, its purpose is to assure:

- That North Carolina youth receive appropriate treatment to meet their needs.
- That all appropriate in-state options are exhausted prior to requesting out-of-state placements.
- That mental health, developmental disabilities and substance abuse services provided to North Carolina youth are appropriate, time-limited, and in accordance with federal and state requirements when out-of-state facilities are utilized.
- That Utilization Review (UR) is consistent and timely for youth residing in out-of-state facilities.

Scope:

This policy and procedure applies to all programs serving youth in North Carolina.

Policy Statement:

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services must assure program compliance and integrity of all federal/state systems of MH/DD/SAS utilized for North Carolina youth in out-of-state (OOS) facilities. This level of assurance impacts and affects the behavioral health service system and guarantees the youth of North Carolina receive quality services both in-state and OOS that are cost effective. The following applies to OOS placements.

- In-state placement for the support and continuity of family involvement is the first priority, with OOS placements as the last option.
- This OOS procedure is in accordance with the Interstate Compact on Mental Health (GS122C-361 through 366).
- Federal guidelines and the Medicaid State Plan (Attachment 3.1-A.1, page 1)[1] state that Medicaid cannot pay for an OOS placement, if an appropriate in-state placement is available. The same rules and standards apply when Comprehensive Treatment Support Programming (CTSP) funds are utilized. CTSP funds are used for OOS placement when youth are not Medicaid eligible or not eligible for other funding sources and have been determined to be CTSP eligible.
- OOS placement is determined by adherence to the "Compliance Verification Protocol for Client Specific, Time Limited Out-of-State Enrollment for Residential Services" and the "Level of Care Criteria for Mental Health and Substance Abuse Treatment Services, Revised Edition, December 2001."
- OOS placement determination will be reviewed with consideration to system of care principles and practices.
- Cost reimbursement for OOS placement is based on adherence to OOS policies and procedures.
- OOS placement will only be considered for youth who have:
  - Co-occurring disabilities, which may include but are not limited to medical problems, that are so complex that only an OOS facility, with specialty programming meets their needs.
  - Not responded favorably to a crisis intervention plan.
  - Met the "Clinical and Initial Authorization Criteria."
- OOS placement is authorized only for Level IV and Psychiatric Residential Treatment Facilities (PRTF).
- Level IV and PRTF requests will follow the guidelines in the "Child Level of Care Criteria for Mental Health and Substance Abuse Treatment Services."
  - Level IV residential requests meet criteria outlined in "Appendix J, Medical Necessity Criteria for Residential Treatment-Level IV / Secure" and "Level D Initial and Continuing Authorization Criteria."

[1] See http://www.cms.hhs.gov for federal guidelines and http://www.dhhs.state.nc.us/dma/ for the Medicaid State Plan.

  - PRTF placement requests for youth will meet the guidelines in the "Medical Necessity Criteria for PRTFs" and the " Level D Initial and Continuing Authorization Criteria."
- DMH/DD/SAS Program Accountability (PA) Section conducts compliance verification reviews to assure compliance with federal, state, and professional standards of care, as well as compliance with rules and regulations for North Carolina youth receiving residential treatment services OOS.
- Utilization Review (UR) protocol: Level IV: The area program (AP) / local management entity (LME) must send the initial authorization to EDS and to ValueOptions (VO) for youth with Medicaid. The AP/LME conducts the initial authorization for 30 days, with VO conducting the UR starting on the 31st day.
  - PRTF: The AP / LME sends the Certificate of Need (CON) and the initial authorization to VO. VO conducts the pre-admission review and continued stay review. On-going UR is also conducted by the AP / LME with active case management involvement.
- OOS placements utilizing CTSP funding are youth specific and time limited.
  - UR takes place every 30 days beginning the month following admission to the facility.
  - Continued Stay requires clear rationale and the youth meeting continuing medical necessity criteria.
  - Copies of the UR are sent monthly for review to both PA and Child and Family Services (CFS).
- The UR process uses the following criteria:
  - *Level IV ("Appendix J, Medical Necessity Criteria," "Continuation/Utilization Review for Residential Treatment - Secure" and "Service Maintenance Criteria.")*
  - *PRTF ("Criteria for PRTF, Continued Stay").*

NOTE: Appendixes for Initial Criteria for Level D., Initial and Continuation Criteria for Level IV, and PRTF Criteria are included as hard copies.

Enforcement:

Reviews conducted by Program Accountability staff and Utilization Reviews will follow procedures to assure compliance with the policy.

Exceptions:

No exceptions are allowed.

♦♦♦♦♦

Procedure:

Responsibility:	**Action:**
Area Program (AP) / Local Managing Entity (LME)	1. Completes the OOS Placement Request Form with checklist and supporting documentation. 2. Contracts with the OOS facility when utilizing CTSP funding for treatment and room and board. 3. Acknowledgement statements are signed by the AP Director, the Child and Family Team, and the Community Collaborative are aware of the OOS placement referral. 4. Forwards the "Compliance Verification Protocol for Client Specific, Time Limited Out-of-State Enrollment for Residential Services" packet to CFS, Raleigh, NC. 5. Submits copies of the UR to CFS and PA following the UR guidelines.
Representative of the Child & Family Service Section (CFS)	1. Documents receipt of the request packet, checks the document for completeness, and conducts a determination when all requested information is submitted. A status update on the youth may be requested. 2. Within approximately two weeks of the date of receipt, the representative: ♦ Will review documentation for Medical Necessity and make recommendations for clinical appropriateness for OOS placement. ♦ May require additional information from the AP / LME, extending determination time. ♦ Will recommend or deny OOS placement. 3. If placement is approved CFS will: ♦ Identify the OOS placement facility appropriate to the needs of the youth. ♦ Forward the "Compliance Verification Protocol for Client Specific, Time Limited Out-of-State Enrollment for Residential Services" to the Program Accountability Section for compliance verification. 4. If placement is denied CFS will send a letter to the AP, including a copy of the appeal process. 5. For direct enrollment CFS will provide to the OOS facility the following: ♦ Medicaid: information regarding the enrollment application for reimbursement from Division of Medical Assistance (DMA), or ♦ CTSP: information regarding contracting with the A/P for treatment and/or room and board.

Program Accountability Section (PA) staff

1. PA is responsible for determining equivalency of OOS facility standards as compared to North Carolina standards. In this capacity,
2. PA will:
   - Document receipt of the approved OOS request from CFS.
   - Review the completed packet within approximately two weeks for compliance verification needs.
   - Confirm the six month Compliance Verification form or request the facility to complete Compliance Verification form, while not repeating compliance verification on facilities or units within facilities with current compliance status.
3. Compliance Verification involves:
   - An application packet is sent to the OOS facility.
   - OOS facility administrator is contacted by telephone regarding the compliance verification process.
   - Contact OOS and service agencies to assure the good standing of the OOS facility.
   - Contact DMA concerning reciprocity with other OOS facilities.
   - Request additional information from CFS as needed.
   - If approved:
     - CFS will complete and send to PA and DMA official approval documentation and copies of the "Compliance Verification Protocol for Client Specific, Time Limited Out-of-State Enrollment for Residential Services."
     - CFS and the AP/LME are notified in writing.
     - PA and CFS will review for UR following the UR guidelines identified on page four.
   - If denied:
     - CFS, the AP/LME and DMA are notified in writing.
     - Denials will include an appeal process.

Representative of the Division of Medical Assistance (DMA)

1. The representative of DMA will:
   - Review facility enrollment status.
   - Review rate setting for the PRTF.
   - Notify CFS and PA in writing regarding denials / acceptances.
2. If approved, DMA will:
   - Provide written notification to the AP/LME.
   - provide written notification to CFS and PA
3. If denied DMA will:
   - Provide notification to the case manager / AP/LME.
   - Provide notification with the appeal process to the family member and/or legal guardian.

LIST OF ATTACHMENTS

- OOS Placement Request Checklist and Placement Request Guideline Form
- Support Statement
- PRTF Criteria, Medicaid Special Bulletin IV December 2001
- Child Levels Of Care Criteria for Mental Health, Developmental Disabilities and Substance Abuse Treatment Services, Revised Edition August 2001
- Directory of Contacts
- Web sites

PROCEDURES FOR OUT-OF-STATE PLACEMENTS

Out-of-State (OOS) Placement Request Checklist

Prior to filling out the referral procedure form, review the checklist to see that all in-state resources have been exhausted and that you have all the information and documentation necessary to complete the referral packet.

Check the appropriate answer. If the answer is N, explain.

1.)	Client Information			
	♦ Unique ID or ID #		Y	N
	♦ CAFAS score		Y	N
	♦ NC-SNAP Score		Y	N
	♦ Medicaid number	N/A	Y	N
	♦ Life Chart	N/A	Y	N
	♦ parent or legal guardian involvement		Y	N
2.)	Integrated Service Plan revision		Y	N
3.)	Crisis Plan		Y	N
4.)	IEP	N/A	Y	N
5.)	Diagnostic categories & rule/out diagnoses		Y	N
6.)	Medications (including those for medical purposes)		Y	N
	♦ dosages/targeted signs and/symptoms		Y	N
	♦ involuntary movement scale		Y	N
	♦ behavioral concerns/issues	N/A	Y	N
7.)	Psychosocial history		Y	N
	♦ addendum	N/A	Y	N
8.)	Treatment Summary		Y	N
	♦ current clinical treatments/interventions identified		Y	N
	♦ placement history		Y	N
9.)	Current Residence/needs/effectiveness		Y	N
10.)	Other supporting information	N/A	Y	N
	♦ documentation	N/A	Y	N
11.)	All applicable in-state resources explored		Y	N
	♦ facilities/ level/ denial dates/reasons/appropriateness	N/A	Y	N
	♦ wait list time documented	N/A	Y	N
12.)	Level of Care defined by appropriate criteria		Y	N
13.)	Alternative plan to OOS placement		Y	N
14.)	Discharge plan		Y	N
15.)	Step down plan for in-state services		Y	N
16.)	Funding source(s) Medicaid/CTSP/ room & board		Y	N
17.)	Signed acknowledgment/support statement by			
	♦ Child and Family Team and the Area Director		Y	N
	♦ Community Collaborative and the Area Director (CTSP youth)	N/A	Y	N
18.)	Information sent to		Y	N
	♦ the OOS Referral Packet to the State Office		Y	N
19.)	Checklist completed and included with referral packet		Y	N

Placement Request Guideline Form:

- Read the guidelines and form carefully **as procedures have changed and are effective immediately.**
- Type the form (the form is available electronically--see the included list of web sites).
- **Current** is indicative and descriptive of the youth's present level of functioning.

Complete the following and attach the supporting documentation.

1. Client Information:

- First Name/Last Initial/ Unique ID & or ID #:_____ ___ _____
  (Enter the score, number or check if available)
  - CAFAS score __ NC-SNAP score_____ Life Chart ____Medicaid number_____
  - Identify how the parent or legal guardian is involved
    _____

2. Integrated Service Plan (include revised goals and outcomes on return to in-state services):

3. Crisis Plan

4. IEP (when appropriate and to include educational goals / outcomes during the OOS placement):

5. Current Diagnosis (Include Rule/Outs-Use DSM IV Criteria):

I: _____
II: _____
III: _____
IV: _____
V: _____

6. Medications and Targeted Signs/Symptoms (Current medications: target signs / symptoms/ behaviors--include dosages):

♦ **Medications**	**Dosage**	**Signs/ Symptoms /Behaviors**
Ex. Resperdal Tegretol	2 mgs Day 200mgs. BID	Hearing voices , clear thinking Reduce impulsivity, aggressive behaviors

- **If prescribed an anti-psychotic medication** include an abnormal involuntary movement scale (ex. AIMS)
- **Behavioral Concerns and Issues:** (relate to the identified diagnostic criteria)

_____
_____
_____

7. Psychosocial History (if more than a year old, include an addendum update).

8. **Treatment Summary** includes documentation that supports the DSM-IVTR multiple axes:

- List and document (summaries, assessments, recommendations and evaluations for all specialized therapies or interventions including but not limited to family/individual therapy, neurological [seizure disorder / TBI], assessments for MR/DD [a standardized cognitive measurement scale such as the WISC-R or Stanford Benet, adaptive measurement scale such as the Vineland, and a functional analysis [to determine the etiology of problem behaviors] and psychiatric evaluations. If sexual offender behavior is identified, include specifics & dates of the offense(s), adjudication date, offender's evaluation & a risk of re-offending checklist. If substance abuse is identified, use assessment tools such as tools from the Majors Program or the Treatment Improvement Protocol Series (TIPS).

_____

_____

_____

Placement history:

Dates: Admission / Discharge	**Residential**	**Hospitalizations**

9. Identify current residence and needs not being met: Residence: _____

Needs	**Explain How An OOS Facility Will Provide *More Effective* Treatment**

10. Other information: support need for OOS placement (i.e. dated, documented incidences [school, residential], police, etc.

_____

_____

_____

11. Explore All Applicable In-State Resources (consult with Regional Service Managers, C & F Team and the Community Collaborative (if utilizing CTSP funds.) This includes:

- applications to all appropriate in-state facilities according to the requested level i.e. PRTFs or Level IV. (If the facility is deemed inappropriate, **explain.** Include facility denial documentation. Add rows as necessary.)

Facility/Level	**Denial Date**	**Denial Reason(s)**	**Pending Date**	♦ **Inappropriate / Explain**

12. Identify the Level of Care Needed:

- **Level IV** (use Level D **Initial** Criteria- see appropriate attachments):

_____

_____

- **PRTF:** (use the Medicaid PRTF service definition, **admission** criteria--see appropriate attachments.):

  _____

13.) Identify an alternative plan should OOS placement not be possible (include residential and treatment interventions--be specific):

_____
_____
_____
_____
_____

14. Discharge Plan:
Level IV (*Discharge Criteria* for Residential Treatment - Secure--see appropriate attachment):

_____
_____
_____

PRTF (use the PRTF *Discharge* Criteria-see attachment):

_____
_____
_____
_____

15. Step Down Plan for In-State Residential Services & Treatment (be specific- identify residence, services, family/legal guardian involvement).

_____
_____

_____
_____
_____

16. Funding source(s) for Treatment and Room & Board (CTSP, Medicaid, DSS, other):

_____
_____
_____

17. Signed Acknowledgment/support statement :
- Child & Family Team and Area Program Director (attachment).
- Community Collaborative and Area Program Director (CTSP youth) (attachment)

18. Submit:
- OOS Placement Referral Packet to the State Office CFS Section

19. Complete the checklist and include with the referral packet.

Area Program: _____

CTSP Coordinator / Case Manager Supervisor: _____ Phone: _____

Case Manager:
_____Phone:_____

Date Submitted:
_____

North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services
3015 Mail Service Center • Raleigh, North Carolina 27699-3015
Tel 919-571-4900 • Fax 919-571-4878
Michael F. Easley, Governor
Carmen Hooker Odom, Secretary
Richard J.Visingardi, Ph.D., Director

Out-of-State Placement Acknowledgement/ Support Statement

Area Program/Local Management Entity: _____
Client UID/ID Number: _____
Date: _____

I am involved in the planning process for the "Compliance Verification Protocol for Client Specific, Time Limited Out-of-State Enrollment for Residential Services", through the Child and Family Team and / or the Community Collaborative meetings. I agree that all In-State resources are exhausted and all requested documentation is included in this referral packet.

By signing this statement, the Area Program / Local Management Entity agrees to adhere to the Policies and Procedures of the "Compliance Verification Protocol for Client Specific, Time Limited Out-of-State Enrollment for Residential Services" document.

Area Program Director: _____
Child and Family Team Representative: _____
Community Collaborative Representative: _____

PRTF CRITERIA

N.C. Medicaid Special Bulletin IV December 2001
22

PRIOR APPROVAL PROCESS FOR PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

The prior approval process for PRTF begins when the area mental health program becomes aware that a recipient is in need of services. An assessment is done to determine medical necessity and the appropriate level of care. Once the level of care is determined, the case manager from the area mental health program will contact the independent utilization review contractor for Medicaid. The case manager will provide pertinent recipient information by telephone to the utilization reviewer.

Federal regulations require a certification of need (CON) form to be completed prior to admission when the recipient is already Medicaid-eligible or Medicaid is pending. The CON must meet all federal requirements and a copy must be maintained in the recipient's medical record. If application for Medicaid is made after admission, a CON must be done at the time the application is made and the independent utilization reviewer contacted immediately so that review can begin. Authorization for payment will be determined by the latest date of a signature on the CON form.

The following is the minimum data required from the facility representative in order to complete a preadmission certification review:

1. a DSM-IV diagnosis on Axis I through V
2. a description of the initial plan of care relating to the admitting symptoms
3. the current symptoms and precipitating factors requiring inpatient treatment
4. medication history
5. prior hospitalization
6. prior alternative treatment
7. appropriate medical, social, and family histories
8. proposed aftercare placement/community-based treatment
9. the recipient's Medicaid identification (MID) number
10. recipient's name, date of birth, county of eligibility, and sex
11. residential facility name, provider number, and planned date of admission

Reviewers will request the transmittal of appropriate medical records or additional written documentation, as necessary to complete the review. Concurrent review will occur every 30 days.

CRITERIA FOR PRTF

Service definition

Psychiatric residential treatment facilities provide care for children who have a mental illness or substance abuse/dependency and who are in need of services in a non acute inpatient facility. This service may be provided when an individual does not require acute care but requires supervision and specialized interventions on a 24-hour basis to attain a level of functioning that allows subsequent treatment in a less restrictive setting. This service is unavailable for those over 21 years of age or who are in treatment at age 21. Continued treatment can be provided until the 22nd birthday as long as it is medically necessary. Discharge planning starts on the day of admission.

Commission on Accreditation of Healthcare Organizations; the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation. In addition hospital licensure or 122C licensure is required. This program must be provided under the direction of a board eligible/certified child psychiatrist or general psychiatrist with demonstrated experience in the treatment of children and adolescents, and the services must be therapeutically appropriate and meet medical necessity criteria as established by the state. Documentation requirements must meet both the requirements of the accrediting body
And Medicaid guidelines.

A certification of need (CON) process is necessary and must be performed by an independent team that includes a physician who has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and has knowledge of the individual's situation. (taken from CFR 441.153) An individual comprehensive service plan must be developed, implemented and managed on an ongoing basis.

For an individual who applies for Medicaid while in the facility/program, the certification (CON) must be performed by the team responsible for the plan of care and cover any period prior to the application date for which the facility is seeking to have Medicaid coverage begin.

The certification of need for PRTF services must certify that

(1) Ambulatory care resources available within the community are insufficient to meet the treatment needs of the recipients and
(2) The patient's condition is such that it requires services on an inpatient basis under the direction of a board eligible/certified child and adolescent psychiatrist or general psychiatrist with experience in treating children and adolescents and
(3) The services can reasonably be expected to improve the recipients' presenting condition or prevent further regression so that the services will no longer be needed.

It should be noted that adolescents who appropriately require this level of care may have demonstrated unlawful or criminal behaviors. Therefore this level of care may be court ordered as an alternative to incarceration. This court order does not automatically certify, the medical necessity criteria must be met for certification.

Criteria for Admission:

1. Must meet Level D in the MH/DD/SAS Level of Care Document

2-The need for this level of treatment arises from a mental health or substance abuse diagnosis (DSM IV) which requires and can be reasonably expected to respond to therapeutic interventions.

AND

3-The child/adolescent 's condition is not amenable to treatment outside a highly specialized secured therapeutic environment under daily supervision of a treatment team directed by and with 24 hour access to a board eligible/certified psychiatrist or general psychiatrist with experience in treating children and adolescents

OR

4-Less restrictive levels of care (Levels 1-4) have been attempted within the last 3 months and have failed or been ineffective with history of poor treatment compliance.

OR

5- The child is not at an acute level but is in need of extended diagnostic evaluation to determine appropriate treatment

AND

6-The child/adolescent can reasonably be expected to respond favorably to the specialized therapeutic interventions/modalities employed by the Psychiatric Residential Treatment Facility

Continued Stay Criteria:

1- Spectrum of symptoms leading to admission have not remitted sufficiently to allow discharge to a lower level of care or the client has manifested new symptoms or maladaptive behaviors which meet initial authorization criteria and the treatment plan has been revised to incorporate new goals and
2- Patient shows continued progress towards goals as reflected in documentation and treatment plans must be adjusted to reflect progress and
3- The patient's family, legal guardian and/or home community is actively engaged in treatment and ongoing discharge planning or
4- Indicated therapeutic interventions have not yet been employed

Discharge Criteria

1-Patient's needs can now be met at a less restrictive level of care
2 Community placement/supportive services package exist that is able to adequately meet the needs of the recipient
3- Treatment goals related to problems leading to admission have been adequately met.
4-Legal guardian has withdrawn consent for treatment
5-No evidence of progress towards treatment goals and the treatment team has no expectation of progress at this level of care

This program will not be used when the primary problems are social or economic (placement issues) alone. Medical necessity must be evident. Utilization review will be performed by an independent utilization review contractor, every 30 days by a telephonic review. All denials will be based on physician review decisions.

CHILD LEVELS OF CARE CRITERIA
FOR
MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES
Revised Edition
December 2001

It is the philosophy of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) to provide quality treatment to all children and adolescents and their families based on the child's needs with the ultimate goals of independence, self-autonomy, and fulfilling innate potential. By developing a partnership with the child and family and providing the right intensity of service at the appropriate time, this philosophy shall be achieved.

The Child Levels of Care criteria provide a framework for considering authorization of medically necessary services for child mental health and substance abuse disorders provided with state or federal funding, including Medicaid recipients up to age 21 who are eligible for services under EPSDT. The Initial and Continuing Authorization Criteria describe the clinical indicators that should exist in order to consider authorization of a particular treatment service. Together, the Levels of Care criteria and the Initial and Continuing Authorization Criteria create a protocol to guide the decision-making process for making initial authorization, continuing authorizations, and facilitating appropriate care management.

The Levels of Care criteria were developed through an extensive committee and client feedback process. Statewide use of this protocol for all state and federal funding promotes consistency in matching treatment resources with identified medical needs.

AUTHORIZATION PRINCIPLES FOR ALL LEVELS OF CARE

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/ DD/SAS) is committed to addressing the mental health and substance abuse treatment needs of all children.

1. Treatment must be medically necessary: there must be a current diagnosis reflecting the need for treatment and the service must be necessary to meet specific preventive, diagnostic, therapeutic, rehabilitative, palliative, or case management needs of the child.
2. Treatment will be rendered at the most clinically appropriate level of care in the least restrictive, least intensive manner.
3. Access to treatment will be responsive according to accepted standards of care, using strength-focused, family-centered models. The models will utilize collaborative efforts between treatment providers and child and family members (as appropriate) in defining presenting problems in solvable terms, setting realistic goals/expectations for change, utilizing time effectively in treatment,

generating solutions rather than focus on the origin of the problems, and building on family strengths and resources and community resources.

4. Treatment is provided where there is a demonstrated deficiency in adaptive functioning as evidenced by the clinical signs and symptoms of a DSM-IV mental health or substance abuse diagnosis.*
5. In general, treatment is provided to alleviate problems associated with most DSM-IV Axis I diagnoses and/or to lessen manifestations of symptoms of Axis II diagnoses and treatment is aimed at restoring the child to a previous level of adaptive functioning or to a new level of functioning at which the child can be maintained or, in certain instances, at preventing relapse or deterioration from the present level of functioning.
6. The general outcome of treatment should be improved adaptive ability, prevention of relapse or decompensation, or, in emergency situations, stabilization.
7. Treatment is conducted with the rehabilitation of the child as the primary concern. Levels of Care assignment will be driven by the child's need for mental health and/or substance abuse treatment and cannot be used to assume a shift of service responsibilities from other child-serving agencies to the Area Program. The Levels of Care will be used to provide treatment alternatives to families that maximize appropriate responsibility taken for their children.

These criteria are for the explicit purpose of making authorization decisions for children in need of MH and SA services provided with state or federal funding. The services in the child and family continuum of care are provided through age 17, with the exception of individuals who are certified for Medicaid and eligible for services under EPDST up to age 21.

The utilization review process allows for: 1) the provision of core services which do not require authorization before initiation and 2) those services which must be authorized before treatment is initiated.

SERVICES WHICH REQUIRE PRE-AUTHORIZATION

The period of authorization may be less than but not more than the timeframe indicated. Reauthorization must occur prior to the expiration of the previous authorization for continuation of the service. The following services require authorization prior to ***the service being delivered:***

Community-Based Services (CBS) (Group and Individual)
For clients receiving less than 8 hours of CBS per day, the utilization review timeframe should not exceed the limits of the authorization period. For clients receiving 8 hours of CBS per day, utilization review must be conducted at a minimum of every 90 days. A step-down plan of action and/or clinical justification must be documented in the service plan for clients receiving more than 3 hours of CBS per day.

Day Treatment/Partial Hospitalization
Utilization review must occur every 6 months.

Assertive Community Treatment Team
The Assertive Community Treatment Team is an all-inclusive service where a combination of treatment services is integrated into ACTT. Utilization review must occur every 6 months.

Residential Treatment – Family Type/Family-Program Type/High/Secure
The prior approval process for residential treatment begins when the area program becomes aware that a recipient is in need of services. An assessment is conducted jointly by the area program and the Child and Family Team to determine medical necessity and the appropriate level of care. Once the level of care is established for residential treatment Levels II, III, and IV in facilities with four beds or more, the case manager will then contact Value Options in order to provide pertinent recipient information by telephone to the utilization reviewer. At the time of admission, the case manager will give the authorization form to the residential facility to submit to EDS.

Level I Residential Treatment Family Type: Utilization review must be conducted at a minimum of every 30 days and must be so documented in the service record.

Level II Residential Treatment Family-Program Type: Utilization review must be conducted at a minimum of every 30 days and must be so documented in the service record. Concurrent utilization review by Value Options for Level II begins after the first 120 days.

Level III Residential Treatment – High: Utilization review must be conducted at a minimum of every 30 days and must be so documented in the service record. Concurrent review by Value Options for Level III begins after the first 120 days.
Level IV Residential Treatment – Secure: concurrent review by Value Options for Level IV begins after the first 30 days.

CHILD MENTAL HEALTH AND SUBSTANCE ABUSE
LEVELS OF CARE
INITIAL AND CONTINUING AUTHORIZATION CRITERIA

Level D

Level D: The Utilization Management process determines that the child is in need of one or more of the following in addition to or instead of Level A, B, and/or C:

- Assertive Community Treatment Team
- Facility-Based Crisis Intervention
- Residential Treatment – High
- Residential Treatment – Secure

*Note: The medical necessity criteria, continuing utilization review criteria, service maintenance criteria and discharge criteria for each service can be found in the Appendix.

Initial Authorization Criteria for Level of Care D

1) The client is under age 21, is enrolled in Child and Family Services and has a diagnosable DSM-IV mental health disorder or substance abuse or dependency diagnosis,

OR

Is five (5) years of age or younger and shows evidence of significantly atypical development.

AND

2) The child has been in inpatient treatment, residential treatment or in-home supervision for a mental health disorder within the past three (3) months,

OR

Made serious suicide attempt within the past three (3) months,

OR

Total CAFAS score equal to or greater than 90,

OR

Total CAFAS score is greater than 60 but it is determined that appropriate functioning depends on receiving a specific treatment and withdrawal would result in a significant deterioration in functioning.

AND

3) There is reasonable expectation that treatment will remediate symptoms and/or improve behaviors or there is reasonable evidence that the child will decompensate or experience relapse if services are not initiated.

AND

4) The child is experiencing moderate to severe behavioral and/or emotional symptoms, due to a mental health or substance abuse disorder, manifested by a moderate to severe risk for self-injury, injury to others, delay in appropriate developmental progress, deterioration in ability to fulfill age-appropriate

responsibilities, presence of stress-related physical symptoms, decompensation, or relapse.

AND

5) An adequate trial of active treatment at a less restrictive level has been unsuccessful or the child is clearly inappropriate for a trial of less restrictive services.

AND

6) The child is at significant risk for needing the most restrictive level of care and/or return to the most restrictive level of care due to the child's severe and persistent maladaptive behavior in the home and community.

Continuing Authorization Criteria for Level of Care D

1) The child's symptoms or behaviors persist at a level of severity documented at the most recent authorization of this episode of care.

OR

2) Relevant child and family progress toward identified treatment goals has been observed and documented, but initial treatment goals have not been reached.

OR

3) No progress toward treatment goals at the most recent authorization of this episode of care have been documented but the treatment plan has been modified by the treatment provider and child and/or family members (as appropriate) to introduce new therapeutic interventions.

OR

4) The child has manifested new symptoms or maladpative behaviors which meet initial authorization criteria and the treatment plan has been revised to incorporate new goals.

AND

5) There is reasonable expectation that continued treatment would remediate the symptoms/behaviors or there is reasonable evidence that the child will decompensate or experience relapse if services are discontinued.

APPENDIX J: Medical Necessity Criteria for Residential Treatment – Level IV/Secure

In addition to meeting Residential Treatment – High Level III medical necessity criteria, the client is eligible for this service when:

A. Medically stable, but may need significant interventions to comply with medical treatment;

AND

B. Meets the criteria for Level of Care D/ NC Support Needs Assessment Profile (NC SNAP). A Sex Offender Specific Evaluation (SOSE) shall be provided by a trained professional, and a level of risk shall be established (low, moderate, high) using the Risk Checklist for Sexual Offenders, the Juvenile Sexual Offender Decision Criteria, and a Checklist for Risk Assessment of Adolescent Sex Offenders.

AND

The client's identified needs cannot be met with Residential Treatment – High Level III services;

AND

The client is experiencing any one of the following (may be related to the presence of severe affective, cognitive, or behavioral problems or developmental delays/disabilities):

A. Frequent and severe aggression including verbal aggression and property damage and/or harm to self/others and unmet needs for safety, containment of aggressive and/or dangerous behaviors.
   Risk of offending or predatory sexual behavior is high with inadequate supervision that puts the community at high risk for victimization.

B. Severe functional problems as defined in Residential Treatment – High Level III coupled with demonstrated inability to maintain treatment in an unlocked setting as evidenced by, but not limited to, a history of eloping from unlocked facilities, or inability to become stabilized in anything but a locked facility.
C. Medication administration and monitoring have alleviated limited or no symptoms and other treatment interventions are needed to control severe symptoms to ensure safety.
   May be related to the presence of severe affective, cognitive, or behavioral problems or developmental delays or disabilities.
   High-risk for sexual reoffense.
D. Severe limitations in ability to independently access or participate in other human services and requires intensive, active support, supervision and on-site access to all routinely needed services.
E. Severe deficits in ability to manage personal health, welfare, and safety without intense support and supervision, including sexual behaviors.
F. Severe aggressive and dangerous episodes may be without provocation or predictable, identifiable triggers.
   Has deficits that put the community at risk for victimization unless specifically treated for sexual aggression problems.

Continuation/Utilization Review for Residential Treatment – Secure

The client continues to have the need and continues to benefit as outlined in their service plan. The desired behavior or level of functioning has not been restored, improved, or

sustained over the timeframe outlined in the client's service plan; or the client continues to be at risk for relapse based on history or the tenuous nature of functional gains or any one of the following apply:

1. Client has achieved initial service plan goals and additional goals are indicated.
2. Client is making satisfactory progress toward meeting goals.
3. Client is making some progress but the service plan (specific interventions) should be modified to determine if greater gains are possible.
4. Client is not making progress; the service plan must be modified to identify more effective interventions.
5. Client is regressing; the service plan must be modified to identify more effective interventions.

AND

Utilization review must be conducted at a minimum of every 30 days and so documented in the service record.

Service Maintenance Criteria

If the client is functioning effectively at this level of treatment and discharge would otherwise be indicated, this level of service should be maintained when it can be reasonably anticipated that regression is likely to occur if the service were to be withdrawn. This decision should be based on at least one of the following:

A. There is a past history of regression in the absence of residential treatment or a lower level of residential treatment.
B. There are current indications that client requires this residential service to maintain level of functioning as evidenced by difficulties experienced on therapeutic visits/stays in a non-treatment residential setting or in a lower level of residential treatment.
C. The presence of traditional psychiatric diagnoses necessitate a "disability management" approach. In this event, there are epidemiologically sound expectations that symptoms will persist and that ongoing treatment interventions are needed to sustain functional gains.

**Note: Any denial, reduction, suspension, or termination of services requires notification to the client and/or the legal guardian about their appeal rights.*

Discharge Criteria for Residential Treatment - Secure

The client shall be discharged from this level of care if any one of the following is true:

A. The level of functioning has improved with respect to the goals outlined in the service plan and the client can reasonably be expected to maintain these gains at a lower level of treatment.

OR

B. The client no longer benefits from service as evidenced by absence of progress toward service plan goals and more appropriate service(s) is available.

OR

C. Discharge or step-down services can be considered when in a less restrictive environment and the safety of the client around sexual behavior and the safety of the community can reasonably be assured.

**Note: Any denial, reduction, suspension, or termination of services requires notification to the client and/or the legal guardian about their appeal rights.*

DIRECTORY OF CONTACTS

Child and Family Services Section:

Rhoda Miller, CFS, 3015 Mail Service Center, Raleigh, NC, 27699-3015,
919-420-7981, E-mail: Rhoda.Miller@ncmail.net

Program Accountability Section:

Darlene Steele, PA, Mail Service Center 3012, Barrett Drive, Raleigh, NC, 27699-3012,
919-420-7934, E-mail:Darlene.Steele@ncmail.net

Deb Kovalycsik, Community Services #10, WCC, 300 Enola Road, Morganton, NC 28655,
828-438-6486, E-mail: deb.kovalycsik@westerncarolinacenter.org.

Marilyn Godette, PA, 225 Green Street, Ste.506, Fayetteville, NC, 28301, 910-484-1119,
E-mail: Marilyn.Godette@ncmail.net.

Department of Medical Assistance:

Carol Robertson, DMA, Kirby Building, 1985 Umstead Drive, Raleigh, NC 27603-2001,
919-857-4020, E-mail: Carol.Robertson@ncmail.net.

JoeAnn McCullough, DMA, Provider Enrollment, Kirby Building,1985Umstead Drive,
Raleigh, NC 27603-2001, 919-857-4017, e-mail: JoeAnn.McCullough@ncmail.net

WEB SITES

1. **Out of State Placement Procedure / Policy Referral Packet**: www.dhhs.state.nc.us/mhddsas/childandfamily/index.htm, link to Services, Residential, OOS Placement Procedures.

2. **Levels of Care Criteria for Mental Health, Developmental Disabilities And Substance Abuse Treatment Services, Revised Edition, August 2000:** www.dhhs.state.nc.us/mhddsas/childandfamily/index.htm, link to Services, Residential Levels of Care.

3. **PRTF Criteria:** www.dhhs.state.nc.us/dma/, link to Special Bulletin, link to Special Medicaid Bulletins, Mental Health and Substance Abuse Guidelines, Special Bulletin IV, December 2001.

4. **Adolescent Substance Abuse:** www.samhsa.gov/centers/csat/csat.html or jointogether@jointogether.org. (e-mail: Jennifer Resnick: Jresnick@innovationsresearch.com.)